

Colchester Group Practice

Quality report

Colchester
Essex
CO2 7UT

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17 January 2019

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information given to us by the group practice and patient feedback about the service.

Ratings

Overall rating for this service	Inadequate 
Are services safe?	Inadequate 
Are services effective?	Requires improvement 
Are services caring?	Inadequate 
Are services responsive to people's needs?	Requires improvement 
Are services well-led?	Inadequate 

Chief Inspector's Summary

This group practice is rated as inadequate overall

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Inadequate

Are services responsive? – Requires improvement

Are services well-led? - Inadequate

We carried out an announced comprehensive inspection of Colchester Group Practice on 17 January 2019. Defence Medical Services (DMS) are not registered with the CQC under the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014 and are not required to be. Consequently, DMS services are not subject to inspection by the CQC and the CQC has no powers of enforcement. This inspection is one of a programme of inspections that the CQC will complete at the invitation of the Surgeon General in his role as the Defence Authority for healthcare and medical operational capability.

At this inspection we found:

- Feedback about the service from patients was excellent. It showed patients were treated were involved in care and decisions about their treatment.
- Quality improvement was evident for Colchester Medical Centre, including clinical audit used to make improvements in patient outcomes. This was not the case for the Military Correctional Training Centre (MCTC) Medical Centre.
- Staff demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice. This ethos was reflected in the vision developed for Colchester Medical Centre. However, we did find that the privacy and dignity of patients was compromised in the Primary Care Rehabilitation facility (PCRF) at Colchester Medical Centre.
- All the staff we spoke to during the inspection said they supported by the leadership team. They felt respected, supported and valued. Opportunities were in place so staff could contribute to their views about developing the service.
- The vision and strategy of the group practice was not consistently understood between the local management team, regional team and Defence Primary Healthcare (DPHC). Operational objectives and arrangements for monitoring the impact of this new group practice model were not evident at the inspection.
- Leaders had the skills, experience and capability to manage the group practice. However, leadership capacity, including for the PCRF, was insufficient to ensure a consistent and sustainable safe and well-led service.
- Governance activities and working practices were not fully integrated or joined up between the hub and spoke practices, and the PCRF.
- Processes to ensure a safe service for patients were not consistent across the group practice, such as the management of significant events, safeguarding information, chaperoning arrangements and staff induction.

- Although we found some improvement was needed, overall the arrangements for managing medicines were safe.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Facilities and equipment at the practice were sufficient to treat patients and meet their needs. Information to demonstrate safety checks of the environment and equipment were not consistently available for both practices.
- Staff were aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The Chief Inspector recommends:

- The practice ensures that the privacy and dignity of patients is maintained at all times.
- The vision, strategy, operational objectives and strategic monitoring arrangements should be reviewed to ensure they reflect Colchester Group Practice. This information should be made available to the local leadership team and other stakeholders so there is a consistent understanding of the model.
- Staffing should be reviewed to ensure there is sufficient leadership capacity to implement the group practice model. Leaders should be involved in the recruitment of new staff so they are assured that staff have the skills and experience for the roles they are posted to.
- A review of staff induction and training needs to ensure staff have the skills and knowledge to deliver effective care and treatment.
- The governance arrangements should be reviewed with a view to fully integrating all systems and processes to support the group practice arrangements. The review should ensure patient and staff safety systems are strengthened, including the management of significant events, specimen results and measures to maximise staff safety.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team comprised specialist advisors including, a GP, a practice nurse, two practice managers, a physiotherapist and pharmacist. Because of the complexity of the service, we sought additional evidence following the inspection. We also conducted further interviews by telephone with the practice manager and Senior Nursing Officer.

Background to the Colchester Group Practice

Colchester Group Practice is based on an organisational hub and spoke model. Colchester Medical Centre, located on Colchester Garrison, is the hub practice and supports one spoke practice, the Military Corrective Training Centre (MCTC) Medical Centre, located on a separate camp approximately one mile away. The Group Practice is led by a Senior Medical Officer (SMO)

and practice manager. A Regional Clinical Director (RCD) is overall accountable for the quality of care at the Group Practice.

Colchester Medical Centre

Colchester Medical Centre provides primary healthcare and occupational health to a patient population of approximately 3202 military personnel. The primary focus of the medical centre is to maintain force health protection, particularly for units that have occupational health needs associated with high readiness for deployment. The practice does not provide a service for families, dependants or civilian Ministry of Defence employees.

In addition to routine appointments and medicals, clinics are facilitated for asthma management, well-woman, vaccinations, over 40s health checks, smoking cessation, family planning, weight reduction and healthy eating. Maternity and midwifery services are provided by NHS practices and community teams. Patients have access to medicines through the dispensary in the medical centre. A Primary Care Rehabilitation Facility (PCRF) is located on the premises, with physiotherapy and rehabilitation staff working together within the medical centre.

The practice is open from 08:00 to 18:00 Monday to Friday. Patients are advised to attend the local walk-in centre for access to medical cover when the practice closes at 18:00 and before NHS 111 is available at 18:30.

The staff team comprised a mix of full and part time civilian and military staff and included:

- A group practice SMO, brigade SMO and three civilian medical practitioners (one part time)
- A Senior Nursing Officer (SNO) and five practice nurses
- A lead physiotherapist, three physiotherapists and two exercise rehabilitation instructors (ERI).
- Two pharmacy technicians
- A practice manager was responsible for the running of the medical centre supported by a team of four administrators
- A range of Regimental Aid Post (RAP) staff also worked at the practice, specifically in relation to the occupational health needs of units. Regimental posts are front line military medical assets that are the property of a military unit. Posts can include a medical officer, nursing officer and medics. RAP staff deploy with the units they are attached to. In the army, a medic is a soldier who has received specialist training in field medicine. It is a unique role in the forces and their role is similar to that of a health care assistant in NHS GP practices but with a broader scope of practice.

Military Corrective Training Centre (MCTC) Medical Centre

The MCTC Medical Centre provides a primary care service to detainee's; tri-service military personnel under sentence. The patient population fluctuates daily due to new arrivals and sentencing, with a maximum capacity for 200 detainees. At the time of our inspection there were 27 detainees, who were had received a sentence from one week to a maximum of two years. Although not identified as a prison, the MCTC is inspected by Her Majesty's Inspectorate of Prisons (HMIP) and was last inspected in November 2017.

The practice had a dedicated staff team comprising:

- A GP from 08:00 to 12:30 Monday to Friday who then transfers to Colchester Medical Centre in the afternoons
- A practice nurse from 08:00 to 16:00 Monday to Thursday and from 08:00 to 16:30 on Fridays.
- Two medics from 08:00 to 16:30 Monday to Friday.
- A full time ERI and part-time physiotherapy cover from the hub practice.

Patients of the MCTC Medical Centre also had access to clinics provided at Colchester Medical Centre.

Are services safe?

Inadequate

We rated the practice as inadequate for providing safe services.

Safety systems and processes

Group practice systems to keep patients safe and safeguarded from abuse needed strengthening.

- The group practice SMO was the adult and child safeguarding lead and, along with all the GPs, had completed level 3 training. Nursing staff were trained to level 2 training despite assessing and treating patients under the age of 18. All other staff had received up-to-date safeguarding training at a level appropriate to their role. Adult and child safeguarding policies, information about safeguarding and contact numbers were available to staff at Colchester Medical Centre. Staff were not able to provide us with this information for the MCTC medical centre. The two junior medics based there who we spoke with were new to the practice. They said if they had any concerns they would contact the practice manager for advice.
- Staff at Colchester Medical Centre were familiar with safeguarding and demonstrated this through examples of how the safeguarding policy had been implemented at the practice, including liaison with local NHS primary care teams and social services.
- Initial registration at the group practice identified new patients who were vulnerable or subject to formal safeguarding arrangements. All detainees of the MCTC received an arrival medical to determine their fitness (including vulnerability) for detention. Codes were used on the electronic patient record system (referred to as DMICP) to highlight patients who were vulnerable. A database for the group practice was maintained of vulnerable patients.
- In addition, the Chain of Command (CoC) for the detention centre maintained a database of high risk detainees and advised the medical centre staff of any risks. We were advised that all patients of the MCTC were considered vulnerable and the welfare team were actively involved with this patient population. Vulnerable patients were discussed at the unit health committee meetings and the quarterly army welfare team. The practice also liaised with the social workers for the personnel recovery units, which were set up to support military personnel on long term sickness.
- All staff had completed on-line chaperone training. Information advising patients of the chaperone facility was available. Staff had been subject to safety checks to ensure they were suitable to work with young people and vulnerable adults. Staff at the MCTC told us if a female chaperone was not available at the medical centre then a female guard would be asked to chaperone the patient. This is not in accordance with the DPHC policy on chaperoning.
- The full range of recruitment records for permanent staff was held centrally. However, the practice could demonstrate that relevant safety checks had taken place at the point of recruitment, including a Disclosure and Barring Service (DBS) check to ensure staff, including

locum staff, were suitable to work with vulnerable adults and young people. DBS checks were renewed every five years. Arrangements were in place to monitor the registration status of clinical staff with their regulatory body. All staff had professional indemnity cover. Information was in place to confirm staff had received all the relevant vaccinations required for their role at the practice. These recruitment checks were carried out for staff in Regimental Aid Posts (RAP) by the unit or regiment.

- Safe and effective processes were in place to manage infection prevention and control (IPC). IPC leads were identified for both the hub and spoke practices and they were suitably trained for the role. Annual IPC audits had been undertaken for both medical centres. However, the primary care rehabilitation facilities (PCRF) at both practices had not been included in the audits and were undertaking separate audits.
- Environmental cleaning was provided by an external contractor. Cleaning schedules and monitoring arrangements were established. A deep clean schedule for the practices was in place. A walk-around both practices demonstrated that IPC arrangements were at a good standard. Sharps boxes were in-date and available in all clinical areas.
- Systems were in place for the safe management of healthcare waste. Consignment notes were retained at the practice and an annual last waste audit was carried out. The safe handling and disposal of sharps audit was undertaken in November 2018. However, it did not address the risk with sharps bins being transported in the duty car from MCTC to Colchester Medical Centre. This was happening because there was no contract in place for the disposal of sharps at the MCTC.
- Measures to ensure the safety of facilities and equipment were in place for Colchester Medical Centre. The contractor held the certificates and/or monitoring checks for gas, electrical and legionella safety so we were unable to confirm when these had been undertaken. Colchester Medical Centre last had a health and safety audit in 2017. Equipment was checked and maintained according to manufacturers' instructions. Testing of portable electrical appliances and medical equipment was in-date for Colchester Medical Centre and a fire risk assessment was undertaken annually. Firefighting equipment was tested regularly and the office manager tested the fire alarm weekly. Staff were up-to-date with fire safety training and were aware of the evacuation plan. This information was not available for the MCTC so we were unable to provide evidence to confirm environmental, equipment safety assessments and checks had taken place for the medical centre. Both buildings were subject to different contractual arrangements.

Risks to patients

The systems to assess, monitor and manage risks associated with patient safety needed improving.

- Colchester Medical Centre was operating to a full capacity of permanent staff, except for the Primary Care Rehabilitation Facility (PCRF). Staff of the PCRF said they were meeting patient care needs but participation in governance activities and training was being compromised by two key gaps in senior staff. A duty staff rota was in place and a proactive approach was taken to minimise staff absence.
- Staff described how cutbacks and staff consistency had impacted the staffing levels. For example, there were no plans to fill a military nurse and deputy practice manager post that became vacant last year. The nurse had been on sick leave for an extended period and two medics had left in the latter half of 2018. This meant the practice manager was left with no option but to close the MCTC until the staffing level was safe. Patients were instead escorted to Colchester Medical Centre for appointments. Two new medics had been appointed since

November; one had started working there the day before our inspection. Both were inexperienced for the role and were working at times on a day-to-day basis without direct managerial support and supervision.

- To minimise risks associated with continuity, a detailed induction process was in place for locum staff to ensure they were familiar with systems and ways of working in Defence Primary Health Care (DPHC).
- Both practices were equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. An emergency kit, including a defibrillator, oxygen with adult/child masks and emergency medicines were accessible to staff in a secure area of each practice. A first aid kit and accident book was available. Routine checks were in place to ensure the required kit and medicines were available and in-date.
- Staff were up-to-date with the required training for medical emergencies, including training relevant to occupational risk, such as the management of thermal injury and spinal injuries. The staff received sepsis training in January 2019. The symptoms of sepsis were displayed in the patient waiting area and also displayed in every clinical consultation room and treatment room.

Information to deliver safe care and treatment

- Information processes required to deliver safe care and treatment to patients needed improving.
- Individual care records were written and managed in a way that kept patients safe. The care records we looked at on DMICP showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

New patients registering at Colchester Medical Centre had their occupational health records scrutinised by Regimental Aid Post (RAP) staff. Any patients with chronic conditions were identified through the routine searches carried out and followed up accordingly. Patients of the MCTC had a full medical on admission to the detention centre, which would identify any chronic conditions. Occupational health care was not routinely carried out at MCTC as detainees remained registered with the medical centre where their unit was based.

- Staff described a regular loss of connectivity (or 'freezing') with DMICP, which they indicated could impact on patient care. If there was a loss then clinicians hand recorded their notes and updated DMICP at a later point. We were advised that occupational health activity could not continue as clinicians would require access to the patient's records. Nurses said that medication would not be prescribed during a connectivity loss. DMICP connectivity issues had been escalated to the IT resource manager, with the risk currently sitting on the regional Defence Primary Healthcare (DPHC) risk register.
- A system was in place for the management of referrals for the group practice, including internal referrals and those to external secondary care services. All referrals and appointments for patients of the MCTC were coordinated by the Colchester Medical Centre. MCTC medical centre staff informed the patients and guards of appointment times so that suitable escort arrangements could be made. A referral tracker was used to monitor the status of referrals. Urgent referrals were followed up after two weeks. PCRf staff were responsible for monitoring the status of referrals they had made
- The management of samples was not failsafe. The system for processing and transporting samples to the laboratory was good and test results were dealt with promptly. Either the SMO or duty doctor screened all test results on their return and dealt immediately with any urgent

results. However, the current system was not reliable as the sample register was not accurate and there was no auditable track for when samples went missing. We did note that effective action was taken by the practice when samples were persistently rejected due to illegible handwriting. The SNO liaised with the hospital IT department to produce printable patient identification labels for sample bottles. A recent audit showed this new system had led to no further rejected samples.

Safe and appropriate use of medicines

Some of the systems to support the safe handling of medicines needed improving.

- Both a lead and deputy lead for medicines management were identified for the group practice, with the day-to-day management of medicines delegated to the pharmacy technicians. The dispensary worked to the DPHC standard operating procedures for medicines management and these had been signed off by the pharmacy technician. The MCTC had local procedures in place (referred to as unit standing orders) to support the security of medicines once they had been dispensed from Colchester Medical Centre. These had been approved for use by the practice manager. An annual medicines audit was undertaken by the regional pharmacist.
- A record of dispensary stock was held and expiry dates routinely checked. The two pharmacy technicians were responsible for the ordering, receipt and management of vaccines. Medication requiring refrigeration was monitored twice a day to ensure it was stored within the correct temperature range. Vaccines were not held at the MCTC but taken there on an individual basis by a medic and refrigerated until the patient was seen. The MCTC was less than a mile away so there was no breach to the cold chain.
- Prescription sheets at Colchester Medical Centre were securely stored and their use monitored through serial numbers recorded in a bound book. Colchester Medical Centre issued prescriptions sheets to the MCTC but we found they were not fully accounted for as there was no record of receipts.
- Appropriate arrangements were established for the safe management of accountable and controlled drugs (medicines with a potential for misuse). Systems were established to monitor these medicines and minimise the risk of any potential misuse. Accountable and controlled drugs were not held at the MCTC medical centre. Patients prescribed these medicines had them issued in dosette boxes and a form signed by the pharmacy technician and patient.
- Processes were in place for the safe management and/or disposal of medicines, including controlled drugs and uncollected prescriptions. The management of empty gas cylinders at the MCTC was not safe as empty cylinders were transferred by car to Colchester Medical Centre when they should be directly delivered to and collected from the MCTC.
- A process was in place for monitoring any prescribing by secondary care or out-of-hours services. Information received was scanned to DMICP and tasked to the GP who made changes to the patient's medicine record. For patients of Colchester Medical Centre, repeat prescriptions were agreed in writing or in person. A repeat prescription register was maintained that recorded all stages of the process. Patients were informed if a medicine review was needed when collecting their prescription. A consultation was added to DMICP to inform the GP that the patient was due for a review. Patients on repeat medication were reviewed within six to 12 months. For patients of the MCTC, the medics sent repeat prescription requests to Colchester Medical Centre. These were dispensed into dosette boxes and returned to the MCTC.

- The SNO and one of the practice nurses were non-medical prescribers. They had been subject to assessments and checks to enable them to prescribe safely, and attended regular courses and study days to keep up-to-date.
- Patient Group Directions (PGD) had been developed to allow nurses to administer medicines in line with legislation. These were current and signed by the SMO. Nurses had completed the required training. A process, such as an audit, was not in place to monitor the use of PGDs. In addition, medics had received training and had competency checks by the senior nursing officer (SNO) so they could administer vaccines safely and in accordance with Patient Specific Directions (PSD). A PSD is a prescriber instruction for a medicine for a named patient.
- A register to monitor the prescribing of high-risk medicines was maintained for patients of Colchester Medical Centre. Routine searches were undertaken to ensure the register was up-to-date. Coding was used to identify patients taking high risk medicines. A review of patient's records showed their care was consistently and effectively managed. Shared care agreements, if appropriate, were in place and alerts used to identify patients on these medicines. We were advised that no patients of the MCTC were prescribed high risk medicines. The patient population of the MCTC was not included in the searches or register held at Colchester Medical Centre. The SMO was able to confirm no patients at MCTC were currently prescribed high risk medicines. A routine search was not undertaken and this was a risk given the high turnover of patients at MCTC and the potential for a locum GP to provide medical care there.

Track record on safety

- The practice manager was the lead for health and safety and they were suitably trained for the role. They attended the quarterly health and safety meetings for the garrison. Health and safety processes for the Colchester Medical Centre were monitored and reviewed. Health and safety boards were displayed in each of the medical centres. Assessments pertinent to the Colchester Medical Centre were in place, including those for hazardous substances, operating electrical equipment and lone working.
- Staff at MCTC were not aware of any risk assessments for the premises and did not know whether there were risks on the risk register and where it was located. Rather than have staff working on their own, the MCTC was closed in the afternoons and staff transferred to Colchester Medical Centre to work.
- Panic alarms were installed in clinical rooms for staff to use in the event of an emergency and these were tested regularly. We tested a panic alarm at the MCTC and the guards from the centre promptly responded.

Lessons learned and improvements made

- Staff used the electronic organisational-wide system (referred to as ASER) for recording and acting on significant events, incidents and near misses. Once trained, staff were permitted electronic access to the system, including locum staff. Twelve significant events had been raised in 2018 for the group practice. In addition, the ASER system had been used to report and share an example of a quality initiative. Significant events were a standing agenda item at the governance meetings and the practice meetings held every two months.
- We noted on the risk register that a member of staff had been threatened (October 2018) by an unescorted aggressive patient in the waiting area of the MCTC medical Centre. The incident had not been reported as a significant event despite the risk to staff safety, and delayed response from the guards, even though staff had activated the panic alarm. The practice had made the DPHC aware of the incident.

- The incident was investigated through the detention centre Chain of Command (CoC). A request by the practice for patients to be escorted to their appointment with a guard was declined as it was deemed unnecessary by the CoC. A change to practice was made and patients were waiting in the detention centre reception (which is attached to the medical centre) until the GP calls them through. We were unable to determine how this change reduced the risk as the GP or another member of the staff team as patients would still be unescorted.
- It was concerning that the two new medics were unaware of this incident and did not have access to the risk register. At the time of the inspection, they were awaiting access to Sharepoint, the organisation's document storage system where this information was held. A risk assessment had not been completed to minimise the risk of such an incident happening again. None of the medical centre staff were trained in the management of aggression, including restrictive physical intervention training.
- The pharmacy technicians checked for alerts each day. The SNO was advised of relevant alerts which were added to the agenda for discussion at the governance meetings. They were also added to the health governance workbook and emailed to staff if appropriate. Staff advised us that the last alert actioned was in relation to influenza and we noted this was discussed at the November 2018 practice meeting.

Are services effective?

Requires improvement

We rated the practice as requires improvement for providing effective services.

Effective needs assessment, care and treatment

- Processes were in place to support clinical staff to keep up-to-date with NICE (National Institute for Health and Care Excellence), clinical pathways, current legislation, standards and other practice guidance. The main forum for this was through the health governance meetings scheduled for alternate months and involving the full range of clinicians working at the group practice including RAP staff and medics from MCTC. NICE (National Institute for Health and Care Excellence), clinical audit, quality improvement, health promotion and evidence based practice were a standing agenda item at these meetings.
- The practice manager confirmed that due to changes in staffing and lead roles just two health governance meetings had taken place in 2018; in April and October. We noted that neither meeting had been attended by physiotherapists or exercise rehabilitation instructors (ERI).
- In addition, clinicians had opportunities to attend regional forums, such as regional governance meetings, nurse development forums and prescriber forums. The SMO facilitated weekly meetings with the GPs, the nursing team held quarterly meetings and the PCRf team held weekly meetings. Links to all new or updated policy and guidelines were distributed to clinicians by the SNO who was the lead for healthcare governance.
- Patients could use the PCRf to do their own individual rehabilitation programme or attend scheduled classes facilitated by the physiotherapists or ERIs. A comprehensive timetable of rehabilitation classes was available at the Colchester Medical Centre PCRf.

Monitoring care and treatment

The practice used data collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. It is used across many NHS practices. The Defence Medical Services

(DMS) have a responsibility to deliver the same quality of care as patients expect in the NHS. The QOF provides a useful way of measuring this for DMS. Because the numbers of patients with long term conditions are often significantly lower at DPHC practices, we are not using NHS data as a comparator.

We were provided with the following patient outcomes data during the inspection:

- Nine patients were on the diabetic register. Seven patients had a last measured total cholesterol of 5mmol/l or less which is an indicator of positive cholesterol control. Seven patients had a last blood pressure reading of 150/90 or less.
- Twenty-four patients were recorded as having high blood pressure. All had a blood pressure recorded in the last nine months of 150/90 or less.
- Twenty-two patients had a diagnosis of asthma. Seven of these patients had an asthma review in the preceding 12 months which included an assessment of asthma control using the three Royal College of Physicians questions. Staff were pro-actively recalling patients as they should but patients were failing to attend for their reviews. Given the transient nature of this population group, nurses were opportunistically carrying out asthma reviews, such as when patients were attending for occupational health. The Chain of Command was informed of patients who failed to attend for appointments.

The SMO and a practice nurse were identified as the leads for chronic disease management. Each of the nurses had an area of responsibility for chronic disease and all were in a position to manage all areas in the event of a nurse absence. They carried out regular searches of the patient population that also included the MCTC patients. We looked at a selection of clinical records and noted patients were recalled when appropriate and relevant Read codes were applied. We were assured that clinicians were consistent in how patients were reviewed. For example, clinicians used the same asthma review template.

Patients with a mental illness and/or depressive symptoms was being effectively and safely managed. One of the GPs had a background in psychiatry. The practice had a good relationship with the Department of Community Mental Health (DCMH) which was based in Colchester. It also had good links and worked closely with the army welfare service. GPs could approach the psychiatrist for advice or to discuss referring patients to the service. There was a dedicated community psychiatric nurse for the MCTC who provided extended appointments for patients. Services provided by the mental health team included anger management and alcohol counselling.

Information from the Force Protection Dashboard, which uses statistics and data collected from military primary health care facilities, was also used to gauge performance. Service personnel may encounter damaging noise sources throughout their career. It is therefore important that service personnel undertake an audiometric hearing assessment on a regular basis (every two years). Audiometric assessments were in date for 69% of patients.

An audit log was in place for Colchester Medical Centre based on population need. It included both data analysis audits and clinical audits to measure the effectiveness of care. Repeat audits were evident. Some of the audits included: influenza; vaccine uptake; audiometry uptake; downgrading of soldiers; patient waiting times; privacy and dignity; referrals to the DCMH; results handling and a PGD audit. A repeat minor surgery audit was last undertaken in August 2017. An audit of doctor consultation notes had been completed. We noted that an audit of nursing clinical records undertaken in November 2018 lacked objectivity and we highlighted this at the time of our inspection.

Prescribing audits were undertaken and the most recent took place in January 2019. Antibiotic prescribing audits took place in February and December 2017. A student at Colchester Medical Centre completed a detailed audit regarding the prescribing and counselling of patients on their medication. PCRF audits were not included in the audit register. There was no PCRF audit plan for 2018 or 2019 and, whilst audits were taking place, there was very limited evidence of re-audit or implementation of actions for improvement. Besides an IPC audit and smoking cessation audit, we were not provided with any other audits for the MCTC.

Effective staffing

- All staff working at Colchester Medical Centre had received a generic induction to the practice. A role specific induction was in place for nurses and was in accordance with the DPHC framework and Defence Nursing Operational Competencies. The induction for GPs covered the processes and procedures at the MCTC. Not all PCRF staff at both medical centres had completed an induction including the mandatory training.
- There was no specific induction pack for staff working at the MCTC. The two new medics at the MCTC had, or were, completing an induction pack for Colchester Medical Centre, which did not fully address their roles and responsibilities at the MCTC or the needs/risks of the MCTC population.
- The practice manager had a system to monitor the mandatory training of staff. Staff received reminder emails when training was due. Staff also completed training and training updates relevant to the needs of the population. For example, GPs had a range of skills between them including boxing medicals, fitness to parachute assessments, aviation and diving medicals. The SNO monitored the training for nurses.
- Clinical staff, staffing levels permitting, had protected time for professional development. The SNO and SMO had processes in place to monitor the revalidation and continuing professional development (CPD) of staff. We looked at three CPD portfolios for staff and all were in good order and current. Peer review and clinical supervision was facilitated through the GP weekly meetings and the nurses had a meeting once a month. The nurses provided supervision for the clinical work of the medics. All staff were up-to-date with their annual appraisals.
- Staff at the PCRF used clinical podcasts to review practice. They listened to the podcast and then discussed the relevance to their clinical practice.
- Arrangements were in place to monitor the training and competencies of RAP staff working from Colchester Medical Centre. A database was maintained of the training undertaken and competency checks of clinical practice carried out if appropriate. The SNO said that managing the database was a challenge because of the continual turnover of RAP staff. Assurance was provided by the Regimental Medical Officer (RMO) of revalidation and participation in CPD.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. For example, if staff failed to complete mandatory training then their line manager was informed.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- The clinical records we reviewed showed appropriate staff, including those in different teams, services and organisations were involved in assessing, planning and delivering care and

treatment. An effective system was in place for deregistering and the transfer of DMICP notes from one practice to another. Patients of the MCTC received a full medical before discharge.

- The group practice had developed good working relationships both internally and with health and social care organisations. Although informal, the GPs and PCRf staff met regularly to discuss and monitor patients referred to the PCRf. The practice, including the PCRf was represented clinically at the Unit Health Committee (UHC) meetings held each month for both Colchester Medical Centre and MCTC patients. These meetings reviewed the needs of patients who were medically downgraded and those who were vulnerable.
- The group practice also worked closely with the Regional Rehabilitation Unit (RRU) and the DCMH. The practice nurses were resourceful in the relationships they had developed with the practice nurse at Rock Barracks and the nurse at Wimpish Medical Centre. This collective support was demonstrated through supporting each other with IPC inspections, CPD, training and health promotion advice.
- The practice had good links with the local midwifery service and health visiting team. The SNO attended regular meetings with the Clinical Commissioning Group and the hospital liaison officer for 'choose and book' referrals. The SMO was on the Local Medical Committee and Royal College for GPs secure environment group.

Helping patients to live healthier lives

Staff were proactive and sought options to support patients to live healthier lives.

- Clinical records at Colchester Medical Centre showed that staff encouraged and supported patients to be involved in monitoring and managing their health. Staff also discussed changes to care or treatment with patients as necessary.
- The practice supported national priorities and initiatives to improve the population's health including, stop smoking campaigns and tackling obesity. Health promotion material was evident at both the hub and spoke practice. The health promotion displays were refreshed in response to population need and other factors. For example, there was a display in the waiting area of Colchester Medical Centre showing the difference between non-freezing cold injuries, cold injuries and freezing cold injuries. Information about the dangers of smoking was available and also the impact of drink driving.
- In addition to general health promotion, information was available in the PCRf waiting area about conditions, such as correct exercising techniques. A television in the waiting area with an informative programme on musculoskeletal injuries was playing during the inspection. postnatal exercise classes were held at Colchester Medical Centre PCRf.
- The PCRf had developed a range of musculoskeletal information leaflets for the GPs and nurses to distribute to patients but had not done any checks to ensure they were being given to patients.
- A nurse was identified as the lead for sexual health. They and two other nurses had completed the required training for the role. Information was available for patients requiring sexual health advice, including sign-posting to other services. Condoms and chlamydia kits were freely available in the toilets at both the hub and spoke practices. Arrangements were in place for referring patients to the defence sexual health consultant if needed. We were advised that patients generally prefer the anonymity of external screening as results are sent via text to the patient and not recorded on DMICP.
- Processes were in place to identify patients eligible for screening programmes. There was one patient eligible for breast screening and no patients eligible for bowel screening.

- It is important that military personnel have sufficient immunity against the risk of contracting certain diseases. The World Health Organisation sets a target of 95% for vaccination against diphtheria, tetanus, pertussis and polio and measles, mumps and rubella. Based on clinical records, the following illustrates the current 2018 vaccination data for military patients:
 - 95.7% of patients were up to date with vaccination against diphtheria.
 - 95.5% of patients were up to date with vaccination against polio.
 - 71% of patients were up to date with vaccination against hepatitis B.
 - 94% of patients were up to date with vaccination against hepatitis A.
 - 95.6% of patients were up to date with vaccination against tetanus.
 - 73.6% of patients were up to date with vaccination against typhoid.

Consent to care and treatment

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making, including taking consent for minor surgical procedures.
- Clinicians supported patients to make decisions. Consent obtained was recorded in patients' records. The practice monitored the process for seeking consent appropriately. Coding in relation to consent was used for all invasive procedures undertaken, including acupuncture.
- The staff team had not received formal training in relation to the Mental Capacity Act (2005) in August 2018. However, they were aware of the Act and if appropriate they assessed a patient's mental capacity to make a decision i.e. in the case of head injury.

Are services caring?

Inadequate

We rated the practice as good for caring.

Kindness, respect and compassion

Staff supported patients in a kind and respectful way.

- Throughout the inspection staff were courteous and respectful to patients arriving for their appointments.
- Results from the October 2018 Patient Experience Survey showed 37 out of 41 respondents would recommend the practice to family and friends. The 33 CQC comment cards completed prior to the inspection were very complimentary about the caring attitude of staff.
- Colchester Medical Centre had an information network available to all members of the service community, known as HIVE. This provided a range of information to patients who had relocated to the base and surrounding area. Information included what was available from the local unit and from civilian facilities, including healthcare facilities.

Involvement in decisions about care and treatment

Staff supported patients to be involved in decisions about their care.

- An interpretation service, the Big Word, was available for patients who did not have English as a first language. This was last used at CTM about 18 months ago. The staff we spoke with at MCTC were not aware of this translation service and no information was available at MCTC about the Big Word. They said they would contact the practice manager should they need to access a translation service.

- The Patient Experience Survey showed that 37 out of 41 respondents felt involved in decisions about their care. Feedback on the CQC patient feedback cards highlighted that patients received information about their treatment to support them with making informed decisions about their treatment and care.
- There were processes in place to identify patients who had caring responsibilities, including the use of alerts, codes and regular searches. For Colchester Medical Centre, patients who were carers were discussed with the welfare team at a meeting in October 2018. The welfare team for MCTC were proactive in identifying and supporting patients who were carers.

Privacy and dignity

The practice did not always respect the privacy and dignity of patients.

- The layout of the reception area and seating in Colchester Medical Centre meant that conversations between patients and reception could not be easily overheard. A television was playing to minimise conversations being overheard. If patients wished to discuss sensitive issues or appeared distressed at reception they were offered a private room to discuss their needs. Just one patient at a time had access to the waiting area at MCTC.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Clinic room doors were closed during consultations. In the PCRf at Colchester Medical Centre the privacy and dignity of patients was compromised as patients sat side-by-side during consultations and no screens were used.
- The practice could facilitate patients who wished to see a GP, nurse or physiotherapist of a specific gender.

Are services responsive to people's needs?	Requires improvement
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We rated the practice as requires improvement for providing responsive services.

Responding to and meeting people's needs

Services were organised and reviewed to meet patient needs and preferences where possible.

- Staff understood the needs of its population and tailored services in response to those needs. For example, clinics at Colchester Medical Centre were organised around the occupational health needs of service personnel due to deploy, including short notice deployment. There was a clear system in place for force preparation out-of-hours for short notice deployment. The practice manager was on-call and could open the practice within two hours if needed. Twenty-four hour telephone cover was provided by a clinician who would initiate immediate last-minute force preparation as required.
- The CQC feedback comment cards completed prior to the inspection highlighted that it was easy to secure an appointment, in particular a short notice appointment.
- Colchester Medical Centre was located in a new building so the needs of people with a disability had been taken into account in the building plans. All services were on the ground floor and were accessible for patients who were wheelchair users or who had limited mobility. There was designated parking for people with a disability. It was unclear if an access audit as defined in the Equality Act 2010 had not been completed for the MCTC medical centre. Reasonable adjustments had been made to accommodate patients. At the time one of the staff was using a wheelchair and was able to access the building.

Timely access to care and treatment

Patients' needs were met in a timely way.

- Patients with an emergency need were seen that day and routine appointments with both doctors and nurses were within 24 to 48 hours. Double appointments at either the request of the clinician or patient could be made. An emergency clinic (referred to as sick parade) was held each morning for patients of the MCTC and then routine appointments were available with a GP until 12:30.
- Non-attendance at appointments was monitored at Colchester Medical Centre and displayed in the patient waiting area. For example, 20 patients failed to attend their appointment in December 2018.
- Home visits for Colchester Medical Centre patients were available at the discretion of the GP. Information regarding the policy on home visits was not included in the patient information leaflet. Telephone consultations were available with all clinicians.
- There was no patient information leaflet available for the MCTC medical centre.
- At the time of the inspection the next available routine physiotherapy appointment was within the target of 10 working days. Access to ERIs was within two working days. A direct access physiotherapist service was in place and an emergency physiotherapy clinic was available at Colchester Medical Centre from 08:00 to 09:00 each day. The Patient Experience Survey showed that 40 out of 41 respondents had received their appointment at a time that suited them.
- One of the regimental physiotherapists (a RAP post) worked in the Colchester Medical Centre PCRf. They only treated the patients from the regiment but no cover was provided when they were on exercise or absent from the service. Although patients were treated by other physiotherapists in their absence, a local memorandum of understanding had been developed that confirming that the physiotherapist would give notice if absent from the PCRf.
- Colchester Medical Centre until recently had a bedding down facility which was staffed 24 hours a day. This facility had provided an out-of-hours service for patients with an emergency need. Since its closure, patients were advised to contact NHS 111 in an emergency when the practice closed at 18:00 Monday to Friday. We queried what patients should do between 18:00 and 18:30 when NHS 111 commenced. Staff said that advice had been sought from the DPHC on this matter and that patients should be advised to attend a walk-in centre. We highlighted that this was not in accordance with the DPHC policy on 'shoulder cover' which requires patients to have access to a GP between the hours of 08:00 and 18:30 every week day. Staff at the MCTC were unaware of the out-of-hours arrangements.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information was available to help patients understand the complaints process. The group practice managed complaints in accordance with the DPHC complaints policy and procedure. Both a complaints and compliments log was maintained for the group.
- The practice manager was the designated responsible person who handled all complaints. A record of complaints was maintained, including verbal complaints. The last complaint received was in July 2017.

- Any complaints were discussed at the practice meetings and lessons identified. Changes to practice were made if feasible and used to improve the patient experience.

Are services well-led?

Inadequate

We rated the practice as inadequate for providing a well-led service.

Vision and strategy

- The understanding of the vision and strategy for Colchester Group Practice was not consistent between the local management team, regional team and DPHC. While the leaders of Colchester Medical Centre were aware they were responsible for the day-to-day management of the MCTC medical centre, they were not aware the operational structure had been formally redesigned based on a 'hub and spoke'/group practice model. The local management team were unable to provide us with evidence to demonstrate they had been included in any consultation or had been involved in the strategic planning for the new model.
- Furthermore, the local management team were not aware that the practice was now called 'Colchester Group Practice'. None of the information we looked at referred to 'Colchester Group Practice', including patient information and local policies and procedures. The leaders of the group practice, mainly the SMO and practice manager, did not have agreed terms of reference/job description for their expanded role. Without terms of reference, we were unable to confirm their scope of responsibilities within the context of the Colchester Group Practice.
- The DPHC mission statement for the group practice was, "To Provide and commission safe and effective healthcare which meets the needs of the patient and the chain of command". Colchester Medical Centre had developed its own mission statement, "To provide a well led, safe and high-quality patient-centred approach to healthcare, underpinned through a collective and effective system of governance". This mission statement was specifically developed for Colchester Medical Centre. A specific group practice mission statement had not been developed.
- Local managers could not provide evidence to demonstrate how the effectiveness of the group practice model was being monitored strategically to ensure the best possible outcomes for patients.

Leadership capacity and capability

Leadership capacity was insufficient to ensure safe practice.

- There was no evidence available to show how workforce planning had been accounted for in the restructure of the practice model. We were advised that a number of staff posts had been removed in recent years, including the practice manager role at MCTC medical centre. Although the leaders had the experience and skills for their roles, our inspection identified a deficit in management capacity to ensure the group practice model was operationally viable and sustainable. Management capacity of the PCRf was also depleted.
- The needs of the patient population at Colchester Medical Centre were highly demanding meaning the practice manager's time was required at Colchester Medical Centre. On the day of the inspection two new and junior staff were working at MCTC medical centre on their own. Despite having an induction, their understanding of the MCTC service was limited. The practice manager was not involved in the posting of staff to the MCTC therefore had no say in the skills, experience and competencies required for the roles. There was not a deputy manager post that the practice manager could share the workload with or delegate the day-to-day operation of MCTC Medical Centre to.

Governance arrangements

The governance framework needed developing to ensure the delivery of quality and sustainable care.

- There was no information in place outlining the operational objectives of the group practice and how governance arrangements should be fully articulated to encompass the entire patient population.
- The practice worked to the health governance (HG) workbook, a system that brings together a comprehensive range of governance activities, including the risk register, significant events tracker, lessons learnt log, training register, policies, meetings, quality improvement and audit. The workbook was accessible to staff at Colchester Medical Centre but staff at MCTC did not know how to access it.
- Not all governance activities were integrated and working practices were not fully joined up. For example, IPC audits had not taken account of the PCRf facilities and PCRf staff were undertaking their own IPC audits despite being understaffed. The audit register did not include the full range of audit activity undertaken at the PCRf and audit activity for the MCTC was underdeveloped.
- With the PCRf having a separate eCAF and HG workbook to the medical centre highlighted further a disconnect in the governance for the whole practice. The eCAF (Common Assurance Framework) is an internal quality assurance tool, used to monitor safety and performance. The DMS CAF was formally introduced in September 2009 and since that time has been the standard healthcare governance assurance tool utilised by DMS practices to assure the standards of health care delivery within DMS.
- Staff we spoke with at Colchester Medical Centre said there was a clear staffing structure in place and they were aware of their roles and responsibilities, including delegated lead roles in specific topic areas. Terms of reference were in place to support job roles.
- Besides the nurse, the staff team at MCTC were new. We confirmed they had an induction, including spending time at Colchester Medical Centre. The induction was not targeted to their area of work as there was no induction pack for MCTC. We found the staff were unsure about processes and procedures for the MCTC, and did not have access to Sharepoint to source this information. For example, they were unclear about safeguarding arrangements and chaperoning arrangements for the MCTC. Staff at the MCTC said the practice manager was approachable any time for advice and guidance by telephone.
- A range of communication streams were used at the practice. A schedule of regular practice and department meetings were well established. Meetings included those for the practice, heads of department, PCRf, nursing, doctors. Health care governance meetings were not taking place as scheduled. The two that did take place in 2018 did not include clinical staff from the PCRf which meant the PCRf had not been involved in any health governance meetings for over 12 months.

Managing risks, issues and performance

Processes were not effective for managing risks, issues and performance.

- A group practice risk register was maintained and was kept under review. Some systems to manage risk were not failsafe, such as the system for managing samples. The ASER system had not been used to its full effect as a serious incident had occurred at the MCTC that had not been treated as a significant event when it should have been. The outcome of the incident

meant the risk to staff had not been effectively addressed. Processes were in place to monitor national and local safety alerts, incidents, and complaints.

- A business continuity and major incident plan was in place for Colchester Medical Centre. Staff were unable to provide us with these documents for the MCTC.

Culture

- All the staff we spoke to at both medical centres felt supported by the leadership team. They said they felt respected, supported and valued. Opportunities were in place so staff could contribute to discussions about how to run and develop the practice.
- Except for compromising the privacy and dignity in the PCRf, staff demonstrated a patient-centred focus and they said this ethos was promoted by leaders and embedded in practice. This ethos was reflected in the vision developed for Colchester medical Centre.
- The practice had systems to ensure compliance with the requirements of the duty of candour, including giving those affected reasonable support, information and a verbal and written apology. The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. A duty of candour register was in place.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The practice actively promoted equality and diversity and provided staff with the relevant training. Staff felt they were treated equally.

Engagement with patients, the public, staff and external partners

- Patients could provide feedback on Colchester Medical Centre through the routine patient feedback survey. We are unable to determine if the same feedback survey was in place for MCTC. Suggestion boxes were available at each medical centre. However, no forms or pens were available at MCTC for patients to leave feedback.
- The group practice had good and effective links with internal and external organisations including the Regional Rehabilitation Unit (RRU), the DCMH, CCG and local NHS primary care providers.

Continuous improvement and innovation

Despite the complexity of the service and evident gaps in leadership and management capacity, the staff team sought ways to continually make improvements to the service. Some examples include:

- The use of clinical podcasts by the PCRf team as an innovative and contemporary way of keeping current with clinical training and development.
- Liaison with the hospital IT department to produce printable patient identification labels for sample bottles. The introduction of this new labelling system led to no further rejected samples.
- The setting up of rehabilitation postnatal classes by the PCRf.